Chronic Disease Prevention Program
Grant/Contract Deliverables and Expectations

Name of Organization: FY2017 Tribal Contracts

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Background

Wisconsin American Indian Diabetes Prevention funding designated through Wis. Stats.s.20.435 (1) (kf) provides mini-grants to 11 tribal nations to assist in creating community infrastructure to address diabetes prevention and control.

Funding

$22,496 for 11 Tribal Health Departments ($2,045 per Tribe)

Scope of Work Summary

Prevention and control activities related to this funding must be in one of two areas as outlined below:

OPTION 1: Evidence-based Prevention and Control Programs

Increase access of evidence-based programs in community settings for the primary prevention or control of type 2 diabetes. These options below apply to any of the following diabetes prevention and control evidence-based educational programming: National Diabetes Prevention Program, Healthy Living with Diabetes, and/or Living Well with Chronic Conditions.

A. **FOR ORGANIZATIONS WITHOUT PROGRAMS:** become a provider of either the National Diabetes Prevention Program, Healthy Living with Diabetes, or Living Well with Chronic Conditions. Upon completion of this grant, a successful program will have:
   - Staff trained as leaders by the end of 2016 (community health representatives or health care professionals).
   - Actively engaged in participant recruitment
   - Started first class in Spring 2017
   - Initiated brainstorming about a plan for implementing and evaluating referral system into programs, including patients with history of gestational diabetes for the National Diabetes Prevention Program (see item "C" below for CDC resources)

B. **FOR ORGANIZATIONS WITH PROGRAMS 1-2 YEARS OLD:** build a strong program through regular classes and reliable data submission. Upon completion of this grant, a successful program will have:
   - Offered one to two class series per year
   - Satisfied data submission requirements for evidence-based programs
   - Initiated brainstorming about a plan for implementing and evaluating referral system into programs, including patients with history of gestational diabetes for the National Diabetes Prevention Program (see item "C" below for CDC resources)

C. **FOR ORGANIZATIONS WITH PROGRAMS 3+ YEARS OLD:** develop plan and protocol for referral systems into programs to ensure sustainability. Successful referral processes will include 3 of

the 5 elements:

- Satisfied data submission requirements for evidence-based programs
- Designated staff to serve as on-site referral intake
- Trained health care providers to make referrals
- Embedded referrals in EHR
- Diabetes treatment department as part of referral loop

Utilize resources available through the CDC National Diabetes Prevention Program website (http://www.cdc.gov/diabetes/prevention/lifestyle-program/deliverers/screening-referral.html), especially the AMA/CDC Toolkit *Preventing Type 2 Diabetes: A Guide to Refer Your Patients with Prediabetes to an Evidence-based Diabetes Prevention Program* (http://www.cdc.gov/diabetes/prevention/pdf/STAT_Toolkit.pdf).

OPTION 2: Hypertension Control in Patients with Diabetes

Increase use of quality improvement processes in tribal health clinics to improve blood pressure control for patients with diabetes. Successful quality improvement processes will include:

- Create registries to identify patients with diabetes that are not in control (Blood Pressure > 140/90)
- Create protocol to develop an individualized treatment plan that may include lifestyle interventions and/or medication to bring Hypertension under control.
- Utilize resources already developed such as:

  CDC Global Standardized Hypertension Treatment Control Project Toolkit
  http://www.cdc.gov/globalhealth/ncd/hypertension-toolkit.htm

  Million Hearts Action Guides for Clinicians
  http://millionhearts.hhs.gov/resources/action_guides.html

  Blood Pressure Measurement Toolkit: Improving Accuracy, Enhancing Care
  http://millionhearts.hhs.gov/resources/action_guides.html

  Measure Up, Pressure Down Provider Toolkit to Improve Hypertension Control
  http://www.measureuppressuredown.com/HCProf/toolkit.pdf

  Improving the Screening, Prevention, and Management of Hypertension: An Implementation Tool for Clinic Practice Teams
  http://here.doh.wa.gov/materials/bp-management-implementation-tool/13_BPtoolkit_E13L.pdf

Period of Performance: October 1, 2016 – September 30, 2017

Reporting Requirements	Due Date
Progress Monitoring – summary report of successes, challenges, outcomes and technical assistance needs related to diabetes prevention and control	November 2017
Reach (e.g., number of sites, number of people reached)	November 2017
Changes to the scope of work should be discussed with program contact(s) prior to making the changes	As needed